NEWS BULLETIN

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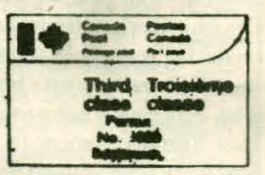

Hospital Agreement Ratified

On May 21, 1986 members of U.N.A.'s Hospital Locals voted by a slim majority (51%) to ratify the Collective Agreement for 1986-87 as negotiated between U.N.A. and the A.H.A. Of 9,383 members eligible to vote, 2,935 voted. Of them 1,498 voted for the contract, with 1,434 against. Eighty-nine Locals voted from a possible ninety-seven, with an overall voter turnout of 31% of U.N.A.'s membership.

The A.H.A. confirmed ratification of the Collective Agreement on June 3, 1986. As a result, the new contract was in effect as of June 3, 1986.

Final corrections to the contract are being completed. Once done, contracts for signing will be sent to Locals. As per U.N.A.'s Constitution, Article 13.05, two (2) Executive Officers of a Chartered Local are required for signing any *Collective Agreement. Following* such signing the Agreement will be prepared in booklet form and sent out for distribution to bargaining unit members.

A summary of points of note in the Agreement is as follows:

Article 1.03 allows a person employed by the Employer subsequent to January 1, 1986 whose employment terminated prior to the date of ratification (June 3, 1986) to apply in writing within 60 calendar days of that date for any retroactive monies owing.

Article 2—the Definitiions Article includes new definitions to cover certified graduate nurses, graduate psychiatric nurses, registered nurses and registered psychiatric nurses.

Article 5.04 provides for a separate union bulletin board in each building where there is considerable geographic separation between buildings where patient care is provided.

Article 6 includes physical disabilities under no discrimination.

Article 7 the Hours of Work Article requires close attention as this includes renumbering of clauses from the previous agreement, changes to previous provisions, and, the addition of new ones. Of particular note is 7.04 (d) relating to day duty and absence on vacation and Named Holidays, and a new definition of extended weekend in Options II and III. In regards to shift exchanges between employees, "where request for approval is made in writing, the Employer's reply shall also be in writing."

Article 8 provides that overtime can be taken as time off at a mutually acceptable time at the premium rate. Where time off is not taken by the "last day of December" overtime is to be paid out. This essentially permits banking of overtime hours.

Article 9 introduces a rate of $1.75/hour for on-call duty assignments, up from the previous $1.50/hour. As well there is a new provision that relates to the determination of pay for call-backs and completion of procedures. There are in addition, new restrictions on the employer regarding the assignment of on-call duty on Saturdays, Sundays, Named Holidays or evenings prior thereto, and, on evenings prior to, or during scheduled off duty days.

Article 10—the Transportation Article clarifies when an employee who is called back to the Institution will receive transportation expenses.

Article 12 clarifies the definition of seniority, broadens its application to include preference for available shift schedules. It requires the Employer to provide a seniority list 3 months from the date of signing and every 6 months thereafter. The seniority list is to include all regular and temporary employees in chronological order. The seniority article also restricts the application of seniority for periods of employment outside of the bargaining unit.

Article 13—the Evaluations Article includes extensive changes. A yearly evaluation in accordance with accreditation guidelines is mandatory. Evaluations are to be done by the employee's "most immediate supervisor in an excluded management position." Advance notice of evaluation interviews is required, of not less than 24 hours. The contents of one's personnel file are to be available for examination at evaluation interviews. An employee may view her personnel file "once every 6 months and in addition when she has filed a grievance." And she must be given a copy of the contents of her file "forthwith" following review of it. Fees for the cost of copying continue to be determined by the Employer.

Article 14—the Promotions, Transfers and Vacancies Article includes new 10 calendar day posting provisions. Vacancies are to be filled from "within the bargaining unit". Vacancy notices are to specify "the number hours/shift and shifts/shift cycle which constitute the regular hours of work of the position". Training is deleted from the list of factors to be considered by the employer in making promotions and transfers. In its place is "experience". A bulletin board for notices is required upon which the names of successful applicants for positions are to be posted "for not less than 8 calendar days". A copy of all postings are to be forwarded to the Union "within 5 calendar days of posting". In addition, each candidate for a position is to be advised "in writing of the name of the successful applicant within 5 working days of the appointment."

Article 15 provides new protection for an employee whose position is eliminated by the employer. It also provides income protection for an employee who may be "displaced" (bumped) as a result of another employee's position elimination job seniority rights.

Article 17 provides an increase in vacation entitlement of 30 working days per year for employees with 25 and more years of service. This provision applies to all employees. A vacation planner is to be posted by the employer by January 1st of each year. Employees are to indicate vacation time preferences by March 15th. If at that time requests for specific periods exceed employee numbers permitted to be absent, seniority shall prevail.

In Article 18, the Floater Holiday and days off for Named Holidays are to be granted at a mutually agreeable time with the ability to bank days off. Failure to reach mutual agreement results in payment for the day. The collective agreement guarantees 3 of the actual Named Holidays off duty and in addition either Christmas or New Year's day off.

New Hospital Contract in effect June 3, 1986

In Article 19, Sick Leave, the Employer agrees to recognize absences from work due to alcoholism, drug addiction, and mental illness therapy as sick leave. When an employee is incapable of performing the duties of her former position on return to work from Long-Term Disability the Employer is required to place her in an appropriate position "upon the occurrence of the first available vacancy." This latter provision is also included in the Workers' Compensation Article.

Article 21 requires the Employer to distribute brochures and other relevant information regarding benefit plans to employees on hire and when changes to the plan occur. Paternity Leave and notice provisions relating thereto are included under Article 22, Leaves of Absence. As well new provisions relating to payment for court Appearances are contained thereunder.

Article 23 Discipline, Dismissal and Resignation includes new protections for employees subject to disciplinary measures by the employer. As well, an employee's disciplinary record is cleared after 2 years if there has been no further discipline during the period. And employees must be given at least 24 hours notice for a disciplinary discussion.

Article 25 Salaries, reflects the inclusion of registered psychiatric nurses in U.N.A.'s bargaining unit, the classificaiton of temporary permit holder and a transitional allowance to be paid of 10¢/hour worked during the period January 1, 1986 to December 21, 1986 inclusive. Educational Allowances as per Article 26 will be paid where the "courses, diplomas or degrees are relevant to exclusive nursing practice" and "granted by bona fide post secondary educational institutions." The hourly allowances for courses are increased, and, being both a member of the AARN and eligible for registration with the P.N.A.A. the employee is paid the amount equivalent to a Clinical Course.

Article 29 includes new pension plan enrollment and buy-back provisions for part-time employees. In addition, all employees are entitled to brochures and relevant information on hire and upon changes being made.

Article 30 which applies to Part-time, Temporary and Casual employees has been modified. Articles that apply to part-time and casual employees have been expanded to include, 11, Probationary Period and 14, Promotions, Transfers, and Vacancies. Temporary employees are entitled to notice in writing of "the number of hours/shift and shifts/shift cycle" for the position that they occupy. Grievance rights have been restricted to include placement pursuant to Article 14.02 or termination pursuant to 30.02 (b). The occasions upon which a part-time employee may work full-time hours have been expanded. Part-timers are guaranteed the same time off duty between shifts, days of rest/week, consecutive days of work and weekends that generally apply to full-time employees. The exception to this is that "when scheduling considerations make compliance with the requirement that designated days of rest fall on a weekend impracticable, such will not be required. Such deviation shall be stipulated in the written advice of hours/shift and shifts/cycle required on hire or transfer." The optional scheduling provisions shall apply. Payment in lieu of vacations with pay shall be paid to casuals "following each pay period". The payment of vacation pay for part-time employees is clarified. Vacation time off "will be deemed to have commenced on the first regularly scheduled work day absent on vacation leave, and continue on consecutive calendar days until return to duty." "The hours of work paid at basic rate and on a *Named Holiday to a maximum of* 7 3/4 hours will be recognized for the purpose of determining vacation pay."

Article 32 the Grievance Procedure Article includes new communication mechanisms for the Employer in the event of grievances. As well, employees at all meetings under the procedure have the right to be accompanied by a representative of the Union.

Article 34 establishes clearly an *Occupational* Health and Safety Committee with provisions similar to that of the PR Committee for its functioning. This includes the right of the Union to present recommendations to the Board of Trustees.

Article 35 identifies inservice programs on CPR, fire, evacuations and disaster procedures, lifting and back injury preventions, as compulsory, and, as being provided to employees on a yearly basis.

Minor changes to Article 36 Professional Responsibility have been made.

Article 37 Extended Work Day has been amended. Positions to which an extended work day applies on each nursing unit must be agreed to and documented in writing between the parties. The agreement may be amended from time to time or terminated by either party by 12 weeks notice in writing. Average weekly hours are now 38.79. Meal period time may not be scheduled during the first or last hour of an extended shift except by mutual agreement. Permanent nights are permitted, with a provision for 14 calendar days of day duty per calendar year for "the purpose of maintaining proficiency." The provisions relating to day duty and absences due to Named Holidays

Continued on page 2

U.N.A. Welcomes Delegates

By: Trudy Richardson
Employment Relations Officer

U.N.A. has had the unique opportunity of welcoming to Edmonton two women from the All China Women's Federation. These two women, Fan Yuhua and Duan Guohui, work in Beijing (Peking) on the International Liaison desk of the All China Women's Federation. This Federation has a total staff of over 100,000 women. Its mandate is to work with women throughout China to improve the status of all Chinese women. While a staff of 100,000 employees in offices over a vast nation staggers the minds of Canadians, and especially Canadian women's groups, it must be remembered that the All China Women's Federation has the overwhelming task of working with and on behalf of half a billion Chinese women. And even with strict government guidelines of "one child per family" it is estimated that the Chinese population will reach 1.2 billion by the year 2000.

Fan and Duan are young, bright, and eager women who bear the responsibility of being the first women sent to Canada from China on a sponsored program by the World University Services of Canada (WUSC). Up until now only men have come to Canada with the WUSC program—engineers, scientists, professors. WUSC was very pleased that this year China sent two women from the All China Women's Federation. Fan and Duan studied English in China but spent a month in Toronto last July brushing up on their spoken English. They then attended Carleton University and Ottawa University in the Women's Studies program. In April they finished these programs and flew to Edmonton to spend May in Alberta. The National Action Committee on the Status of Women had contacted U.N.A. to help plan their itinerary for the month. U.N.A. worked with the Alberta Women's Secretariat and the Alberta Department of Advanced Education, and jointly prepared a proposed list of places, groups, and people Fan and Duan might want to visit. This list was sent to Ottawa in February and the two women selected what was of interest to them. A final itinerary was then developed. Since early May, Fan and Duan have visited the University Women Studies program, the Department of Agriculture's Home Economist offices, the Alberta Women's Secretariat, the Human Rights Commission, the Community College in Grouard, Athabasca University in Athabasca, Fort Edmonton, West Edmonton Mall, Alberta Status of Women Action Committee, Common Woman Books, the Sherwood Park Battered Women's Shelter, a U.N.A. Arbitration In-Service, the Edmonton General Hospital, an election campaign office, the Edmonton Food Bank, the Boyle Street Community Services Coop, the Boyle McCauley Health Centre, Operation Friendship, Urban Manor, the Provincial Museum, the Dinosaur Museum in Drumheller, SAIT in Calgary, a Hutterite Colony near Pincher Creek, the Banff School of Fine Arts, a dude ranch, the Edmonton Soroptomist Club, and the United Nurses' May Board Meeting. They have been invited to homes for dinners and barbecues and have been feted at suppers to welcome them and to hear from them about China. They have eagerly shared their knowledge and experience of China and have very competently answered questions about everything from family planning to Chinese medicine to China's foreign policy. It has been a wonderful experience for all of us to meet Fan and Duan. They leave Alberta for Ottawa to attend the annual general meeting of the National Action Committee on the Status of Women which represents over four hundred Canadian women's groups. They head home to China in July with crammed notebooks and hearts full of memories of a year in Canada. We wish them well and invite any of you who plan to visit China to contact U.N.A. for Fan and Duan's addresses.

FIGHT BACK

Labour Relations Board Looks at Traditional Definition of Nursing Bargaining Unit

by Wendy Danson

The Alberta Labour Relations Board is currently holding a review of the definitions of employee bargaining units within the Hospital Industry. At the moment there are five different bargaining units: Direct Nursing Care, Auxiliary Nursing Care, General Support Services, Paramedical Technical, Paramedical Professional. U.N.A.'s members currently fall within the Direct Nursing Care Bargaining Unit. Since 1977, certificates for U.N.A. Locals have encompassed employees "when employed in direct nursing care or instruction therein". At the time, this definition proved adequate. However, more recently, it has prevented nurses working in other than "direct nursing care" from being in the U.N.A. bargaining unit.

As a result of several applications before the Labour Relations Board requesting it to consider the positions of nurses in other aspects of employment, the Board has undertaken a major project to review the definitions of all five bargaining units. It appears that this affects U.N.A. the most.

U.N.A., in a brief authored by Sheila Greckol, U.N.A.'s Counsel and Wendy Danson, Employment Relations Officer, submitted that the definition of the nursing bargaining unit ought to be broadened to reflect changes and growth in the hospital industry and to reflect the original intent of U.N.A. to be the bargaining agent for all nurses who are employees in the hospital setting. Not surprisingly, the Alberta Hospital Association has submitted a brief requesting a restriction of the bargaining unit definition.

The other issue being addressed by the Labour Relations Board is the issue of "Managerial and Confidential Exclusions". The Labour Relations Act states that a person employed in a managerial capacity or in a confidential capacity in matters relating to Labour Relations be excluded from the bargaining unit. However, the application of this principal has also varied over time. The U.N.A.'s position is that any application to exclude prospective employees from the bargaining unit based upon their exercising managerial functions or their access to confidential information be applied most strictly. The Alberta Hospital Association has taken the position that this provision ought to be applied most broadly.

Public hearings will be held before the Labour Relations Board during the week of June 23 - 27th for the various parties to speak to their written submissions and to provide further evidence where necessary.

Hopefully, the resolution of this matter will result in the clarification of the status of certain nurses who have been found to fall between the cracks of the definitions of the five bargaining units. For example, in Fort McMurray, the Co-ordinator of Manuals and Resources has been found to be an employee, but not to fall within Local 96's bargaining unit. Similarly, in Drumheller, Staff Development Officers and in Fairview the In-Service Co-ordinator have been found to be employees but not within the scope of their respective bargaining units.

Watch the Newsbulletin for a report on the progress of this review.

Beware of AARN

by Michael Mearns

With the proclamation of the Nursing Profession Act in January 1984, the Alberta Association of Registered Nurses (AARN) was confirmed with wide ranging disciplinary authority. Part 7 of the Act deals with discipline in detail. Section 58 permits the Professional Conduct Committee, established in Section 57, to determine, in its opinion, what constitutes unskilled practice or professional misconduct or both. Complaints about nurses' practice or professional conduct may be made by any person, however employers who dismiss nurses for alleged unskilled practice or professional misconduct are obliged by Section 97 of the Act to report the matter to the executive director of the AARN. The report is treated as a complaint.

Upon receiving a complaint the Chairman of the Professional Conduct Committee will appoint an investigator to inquire into the complaint according to Section 62 of the Act. In most cases the individual appointed to investigate will be Cathy Fleming. Cathy Fleming is an employee of the AARN, whose title is Investigations Officer. Any nurse who has a complaint lodged against her will be contacted by Fleming in order to arrange an interview to hear the nurse's side of the complaint. When the Investigator's report is submitted to the Chairman of the Professional Conduct Committee, according to Section 63, she will order either that no further action be taken or that the complaint be referred to the Professional Conduct Committee for hearing.

The investigated nurse may be compelled to be a witness at the hearing. At the hearing the investigator Cathy Fleming will become the "prosecutor" and advance the case against the investigated nurse. The experience of U.N.A. staff is that most complaints result in a hearing.

The alert nurse will see that talking to Fleming during the investigation is a dangerous activity since anything said at the interview may be used in evidence against her. In the past, E.R.O.s have accompanied nurses under investigation to the interviews and the investigator has made it abundantly clear that the nurse can remain silent if she so wishes. The ERO is present for support and advice only.

On one occasion the AARN investigator was joined in prosecuting the case against a nurse before the Professional Conduct Committee by the Executive Director of the AARN, Yvonne Chapman. Later in the case a lawyer was added to the prosecuting team.

The nurse in question though had done everything U.N.A. advised. The advice follows:

If a complaint is lodged against you, contact your ERO immediately. On the basis of past experiences the ERO will advise that you decline to meet with the investigator. This will nearly always result in a Professional Conduct Committee hearing. Upon your request U.N.A. will provide counsel for you at the hearing. Counsel and the ERO will, with your help, investigate, assemble, interview and prepare witnesses and provide a defense at the hearing. No adverse inference may be drawn from your refusal to meet with the AARN investigator.

If the Professional Conduct Committee finds a nurse's conduct constitutes unskilled practice or professional misconduct it may order according to Section 76 of the Act. Section 83 of the Act provides for appeals of the decision to the Appeals Committee of Council and Section 88 provides for a further appeal to the Alberta Court of Appeal.

The best advice U.N.A. can give to any nurse with a complaint lodged against her is say nothing and immediately call a staff person from YOUR organization—that is an E.R.O. from U.N.A.

Arbitration Board Nominee's Controversy

by Micheal Mearns

Does it end here?

The Alberta Court of Appeal finally ruled on 8 April 1986 upholding the Court of Queen's Bench decisions, which disqualified two Employer nominees from sitting on arbitration boards because they appeared to lack the necessary independence of mind. The Court of Appeal heard the case in July 1985.

Since the Court of Appeal ruled in October 1983 that U.N.A. staff members were prevented from sitting as Union nominees to arbitration boards and leave to appeal that decision to the Supreme Court of Canada was refused, U.N.A. has been objecting to Employer nominees where appropriate. The individuals objected to have been personnel directors, labour relations managers and other individuals who are in any way connected with the administration of a U.N.A. collective agreement. U.N.A. had also been successful in a preliminary objection at an arbitration hearing when the Assistant Executive Director — Peronnel Resources of the Alberta Hospital Edmonton (a non U.N.A. hospital) was declared ineligible to participate as a nominee due mainly to his employer's membership in A.H.A.

In the latest Alberta Court of Appeal decision Mr. Justice Stevenson, writing for the majority, chided the employers when he wrote "I must say that the hospitals' *cri de coeur* has a hollow ring as it was a hospital that sought more independence for nominees' when it successfully challenged U.N.A. staff sitting on arbitration boards. Later in the decision Mr. Stevenson said "Where a single industry is governed by a single collective agreement throughout the province it may be difficult to choose nominees familiar with that industry, but the (U.N.A.) locals are entitled to say that the hospitals must lie on the bed they made".

Mr. Justice Shannon dissented from the majority. In his dissent he wrote that "Judicially conceived concepts of bias, apprehension of bias partiality and independence ... have frustrated the intention of the legislature by restricting rather than enlarging the field of candidates available for appointment as arbitrators." Justice Shannon says that the Appeal Court rulings both against Union nominees and the Employer nominees should be resolved by the simple application of Section 122 of the Labour Relations Act, which states:

> No person, shall be appointed an arbitrator or as a member of a board or other body who is directly affected by the difference or has been involved in an attempt to negotiate or settle the difference.

Continued from page 1

and vacations that apply to 7 3/4 hour workers apply. The Article reflects the increase in vacation entitlement during the 25th and subsequent years of employment as well as the appropriate adjustment in % payment on termination.

These changes summarize those agreements made at the bargaining table applicable to the majority of U.N.A. members. Local conditions specific to U.N.A. Locals #1, #79, #121, #2, #32 and #115 are also included. Sepcial reference to such provisions should be made by members of those specific Locals.

The Royal Alexandra Hospital has sent notice of ratification of the contract to U.N.A. of settlement negotiated to cover members of U.N.A. Local #33. In a subsequent newsbulletin no doubt a similar summarizing of changes to the previous agreement and additions thereto will be done.

PROFILES COLUMN

Irene Gouin, author of this newsbulletin's article On Consent Forms was born in St. Paul, Alberta. She graduated from the Royal Alexandra Hospital School of Nursing in 1979. Irene has been employed by the Edmonton General Hospital since June of that same year. She began work there as a full-time nurse on a neurology unit, but is currently part-time, working from the hospital's float pool.

Irene's major interests relate to legalities in health care and educating the public in how to assert their rights.

From 1981-82, as a member of an ad-hoc committee of the AARN, Irene assisted in developing a document entitled, "Guidelines for R.N.'s as patient advocates.". She has presented workshops for the North Central District of the AARN on nursing and health care legalities.

She is actively involved in the activities of the Friends of Medicare. Irene has been a board member of FOM since June 1985. Articles written by her have appeared in Friend to Friend, the newsbulletin of FOM which is published quarterly. As well, Irene has developed and presented a workshop for the organization on the health care system, health care rights and how patients can assert such rights within the system.

Irene has been and continues to be greatly involved in the affairs of United Nurses. Initially a ward representative in 1980, her talents were soon put to use in executive positions for her Local. Irene has been vice-president and treasurer of U.N.A. Local #79. She has served on various Local committees, most notably Professional Responsibility, Labour/Management, Health and Safety and Grievance.

Irene is currently vice-president of Local #79, having been elected during the week of May 23rd.

May Executive Board Synopsis

B. Diepold, Vice-President

The May Executive Board Meeting of United Nurses of Alberta was held May 23 - 30, 1986. Ten observers were present, including Duan Guohui and Fan Yuhua, delegates from the All China Women's Federation.

On Tuesday, May 23, 1986 the Board met as a whole to participate in a Budget Revision and discussion. Committee meetings followed on Wednesday and Thursday, May 28th and 29th, 1986.

The 1986 Annual Meeting Planning Committee presented a Report and it was decided that for the 1986 and future Annual Meetings all arrangements for these meetings would be the responsibility of Provincial office. A "Host Committee" comprised of volunteers will continue to be established.

Arising from District Reports, registrants for Workshops will now be notified by telephone within twenty-four hours of the registration deadline and if the Workshop is cancelled, by a follow-up letter. As well, each new Local will be entitled to have one funded observer at Provincial and District Meetings until they have achieved their first Collective Agreement. It was determined these new Locals needed to attend U.N.A. meetings for information and education. Friends of Medicare and the Hospitals Negotiating Committees also presented Reports.

Investigation Committees were struck to investigate three Locals pursuant to Article 13.05 of U.N.A.'s Constitution. These Committees conducted their investigations during the week of the Board Meeting and presented their recommendations on the final day.

Although Local #53, V.O.N. Calgary remains on strike, following consultation with the Local, the Executive Board decided that financial strike assistance would cease.

Local By-law changes for Local #121—Holy Cross in regards to their Local Annual Meeting were approved. The Legislative Committee reviewed information received from the Canadian Labour Congress but determined that more information was required and therefore would deal with it at a subsequent Board Meeting. List of Contents for Local Kits were reviewed by Membership Services and updated.

Due to financial restraints, the June Labour School was cancelled with the education days allocated for the Labour School reverting back to the Districts for the use in Level I and Level II Workshops. As well, Level II Workshops will be Provincial Workshops, held in Edmonton and Calgary, with the maximum number of participants being raised to thirty, the minimum remaining at ten. Most Level II's have been cancelled in 1986 due to lack of participants, and it was decided that Provincial Workshops would be more cost and time effective as well as provide an increased opportunity for members to attend Level II Workshops. Provincial office will now implement the "NO SHOW" penalties for Workshops, the fee being assessed at $25.00 payable by the Local. However, extenuating circumstances will be considered by the Education Committee if a participant does not attend the Workshop.

The Finance Committee presented a revised 1986 Budget. For the Annual Meeting breakfast and lunch will be provided and funded for all delegates and observers, however no supper (banquet) will be provided. A temporary ERO will be hired to replace a Maternity Leave from September 1986 to January 1987 in the Calgary office. A Provincial Media Workshop will be conducted in December 1986 for Health Unit, VON and Extendicare Locals. District Budgets were reviewed, amended and granted. Video tapes will be investigated or produced as a means of providing membership education.

The Editorial Committee presented additional ideas for the "Profile Column: of the Newsbulletin along with a reminder to the Locals that letters to the Editor and suggestions for articles would be appreciated. District Chairpersons are to submit a summary of their Districts activities for each issue of the Newsbulletin. Publication dates and copy deadlines were revised with the July/August edition being deleted.

The Steering Committee presented an amendment to the Policy regarding "Mailings to the Locals". In future, when information is required for Local Meetings and conducting a Vote, the mailing shall occur three weeks prior to the date of the Vote. Dates for the 1987 Executive Board Meetings were also confirmed. Capital Acquisitions for necessary office furniture as a result of new positions was approved. Renovations to either the Edmonton or Calgary office will not take place at this time.

A motion was passed that U.N.A. oppose Free Trade as it particularly affects Health Care. The Document presented to the Patient Classification Committee will be sent to the Locals in order to share this information with their members.

Dates for the next Executive Board Meeting are August 11 - 15, 1986.

UNA bids farewell to Chris Rawson

After 7 1/2 years as both Employment Relations Officer and Education/Publications Officer with the United Nurses of Alberta, Chris Rawson is leaving UNA to undertake an exciting and challenging new job with the Alberta New Democrats.

Following the recent electoral victories for the New Democrats in the provincial legislature, several new jobs were created. Chris has been hired to fill the position of Media Co-Ordinator, working directly with Pam Barrett, New Democrat House Leader. A newcomer to public relations, Chris is not. Neither is she new to the New Democrats. She has been a strong supporter and worker within the party for many years and it comes as no surprise to many of her colleagues and friends that Chris should be offered such an exciting opportunity.,

But, Chris will be deeply missed from UNA. From the early days of her involvement as the President of the University Hospital Staff

Nurses Association in 1978, through her 6+ years as Employment Relations Officer, her 9 months as Education/Publications Officer, and her period as Acting Executive Director, Chris will leave a very important mark on UNA. The results of her work will remain as records in the Arbitration Cases; workshops reflect her own nursing skills and sensitivity to the issues facing nurses today. Members and colleagues who have worked with Chris will not forget her kindness, sincerity, and dedication to her job and to the union.

We wish you well, Chris. We have every confidence you will succeed in your new career and impress your new colleagues and friends in the legislature as you have us.

Elections 1986

by Nao Fernando,
Employment Relations Officer

Political pundits had predicted a clean Tory sweep. Eighty-three seats in 86, they said. When the smoke cleared 5 Tory Ministers and the Speaker of the Legislative Assembly had bitten the dust. Les Young, the Minister of Labour survived by a slim 70 votes. Eleven of the 17 Edmonton ridings were won by the New Democrats with 44% of the vote.

The conservatives were returned to office with 61 seats, the New Democrats 16 and the Liberal Party 4.

Taking 61 seats out of 83 would have been considered a landslide in another democracy, but not in Alberta, which has been historically electing governments with huge majorities, making the province almost a one party state. It was from this perspective that the print media reacted with headlines such as "Shocker" "Voters Revolt" etc. On T.V. on election night one could see senior Tory party officials running around and scratching their heads in utter disbelief. Finally the Opposition Parties had made a breakthrough. There was going to be a real opposition to the Tories.

The Trade Unions which had worked long and hard to have greater input in the Legislature were relieved and pleased that finally some from their ranks had made it to the Legislature, through the New Democrats. Among those elected were, Ed Ewasiuk the Executive Director of the Edmonton and District Labour Council, Bryan Strong, Business Manager of the Plumbers and Pipefitters Local 488, Pam Barrett former Co-ordinator of Solidarity Alberta, Barry Paschak, a teacher and a member of the Mount Royal College Academic Staff Association Negotiating Committee and a number of other friends of labour. Of particular note is that for the first time 10 women were elected to the legislature.

It was Labours' view that the working people of Alberta were finally getting rid of the mass masochism that had afflicted them into voting for the Tories, in spite of the Tory penchant for bashing the working people in the province with the most obnoxious and reactionary labour legislation in the country.

Can the people of the province now expect the government to be more responsive to the needs of ordinary Albertans? Can they expect fair labour legislation? Will the government now put people before profits?

The next four years should be revealing.

Latest Monthly Statistics

May 30, 1986

EMPLOYMENT INCOME			Previous Month	% Change From Year Age
Average Weekly Earnings ($)	Mar.*	428.36	428.50	3.5
Labour Income ($ million)	Feb.	20,853.9	20,938.5	6.6
Persons with Jobs (million)	Apr.	11.43	11.30	3.8
Unemployed	Apr.	1,303,000	1,380,000	9.3
PRICES				
Consumer Price Index (1981 = 100)	Apr.	131.1	130.9	3.9
New House Price Index (1981 = 100)	Mar.	101.3	100.6	6.4
Raw Materials Price Index (1981 = 100)	Mar.	95.3	104.7	19.6
Excl. coal, crude oil, nat. gas	Mar.	103.2	102.5	1.4
Industrial Product Price Index (1981 = 100)	Mar.	119.9	120.4	1.3
CONSTRUCTION			Year-to-date	
Building Permits ($ million)	Feb.	1,486.4	2,184.5	36.2
Housing Starts—Urban Centres	Mar.	8,517	25,988	23.7
SALES				
Department Store Sales ($ million)	Mar.	900.4	2,358.6	7.8
Manufacturers' Shipments ($ million)	Mar.	21,106.8	61,251.7	6.8
New Motor Vehicle Sales ($ million)	Mar.	1,826.7	1,704.1	14.8
Retail Sales ($ million)	Feb.	9.126.6	18,758.1	11.5

Statistics are in current dollars and are not seasonally adjusted - new this week.

The notion that it's the key to economic recovery is a dangerous myth

THE Regressive CONSERVATIVES

FREE TRADE

Written by John Calvert
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The Mulroney government has stated that it favours the abolition of most remaining trade barriers between Canada and the United States, and that it supports a general reduction in tariffs with the rest of the world. But the "economic revival" promised by the free trade advocates is more likely to be an economic disaster.

Here are the facts:

The issue of free trade with the U.S. has a long history in Canada. In the nineteenth century, bitter political battles were fought between proponents of reciprocity (as free trade was then called) and proponents of high tariffs to protect Canadian industry and keep Canada part of the British colonial trading system.

A century later, the issue is again the focus of major political and economic conflicts. Proponents of free trade with the U.S. argue that access to the larger American market will enable Canadian firms to develop world-scale production facilities. They will allegedly benefit from the efficiencies which accompany large-scale manufacturing processes. They will also, we are told, have a market large enough to justify the expensive capital investments required for world-scale production.

A flawed argument

Those who favour free trade also maintain that Canadian consumers will benefit from lower prices. A North American market would be more competitive, they argue, and Canadians would also benefit from the reduction of tariff charges on consumer goods.

The free trade argument, however, is seriously flawed. First, it ignores the structure of industry in Canada. About half our manufacturing industry is foreign owned, for the most part by U.S. parent companies.

These firms have set up Canadian subsidiaries to produce in Canada because of the tariff walls. When tariffs go down, many of them will simply close their operations and transfer production to their U.S. plants.

Considering that many U.S. manufacturing firms are already in the process of transferring their production facilities from the traditional manufacturing heartland of the U.S. in the North-east to the Sun Belt, or to various Third World countries, it is unreasonably optimistic to expect them to make major new investments in Canada.

Instead, more and more U.S. companies are opening up plants in Mexico, Brazil, Taiwan, South Korea, the Phillipines, and other Third World countries to carry out labour-intensive production. With labour costs only a fraction of those in North America, highly favourable tax arrangements, repressive anti-labour governments, and few environmental or health and safety restrictions, these locations have far lower production costs than Canada.

Jobs will be destroyed

If multi-national companies are permitted to import products from foreign subsidiaries to Canada unimpeded by any trade restrictions, they will have no economic reason for building factories here. The economic costs of allowing them to abandon production in Canada will be enormous — especially for the thousands of Canadians whose jobs will disappear.

A second major reason why free trade is potentially harmful is that much of this trade is not "free" at all. A large proportion of our trade is carried out between Canadian and foreign subsidiaries of the same multi-national companies. Foreign-owned branch plants normally purchase their parts and supplies from their parent firm outside Canada, in preference to domestic sources.

Foreign-owned companies already account for a disproportionate share of our imports, as the accompanying table illustrates.

Canadian Imports by Domestic and Foreign Controlled Enterprises in 1978

Foreign Control (Per Cent)	Value of Imports ($ Millions)	(Per Cent) of Total Imports
75 - 100	24,168	54.3
50 - 75	10.975	24.7
25 - 50	5,938	13.3
0 - 25	3,447	7.7
Total	44,527	100.0

Source: Statistics Canada, *Canadian Imports by Domestic and Foreign Controlled Enterprises in 1978*. Cat. 67-509, 1981.
Note: Figures based on 211 imported commodities. Total imports in 1978 were valued at $50,108 million.

Over two-thirds of our trade is with the United States. The share has been growing over the past decade, as we have become more integrated into the North American market.

A recent study by the Economic Council of Canada revealed that the share of Canada-U.S. imports and exports between foreign-owned Canadian subsidiaries and their parent companies has increased from 66.9 per cent and 63.0 per cent, respectively, in 1965 to 78.9 per cent and 81.3 per cent, in 1979.

In other words, more and more of our trade is controlled internally by multi-national coporations, rather than by the free market.

The following table gives a further breakdown of Canada-U.S. trade patterns.

If existing tariff barriers are abolished, one of the last constraints on internal purchasing arrangements by Canadian subsidiaries of the foreign corporations will be removed. Canadian producers will simply be excluded.

It is ironic that proponents of free trade make no proposals to counter the impediments to trade arising therefrom.

Third World responsibilities

Proponents of free trade also argue that the lowering of tariff walls will benefit poor Third World countries by giving them access to our markets. We're obligated, they argue, to give these countries a chance to develop.

Unfortunately, what is *not* mentioned is that the real beneficiaries of such policies are the multi-national companies operating from these Third World countries. Investors from the U.S. and other developed countries are the ones who profit, not workers in the Third World.

In a world where trade is dominated by an increasingly small number of giant multi-national firms, a policy of abolishing trade barriers has the unintended result of permitting these companies to expand their control over Canadian imports and exports.

Far from resulting in free trade, such a policy leads to the further subordination of Canadian economic development to the dictates of the world's multi-national corporation.

Possible alternatives

There are sensible alternatives to the free trade policies of the new Tory government. The first is the establishment of Canadian content regulations. Such regulations would require multi-national firms to produce in Canada as a condition of having access to the Canadian market. In other words, to sell in Canada a company *must* produce in Canada.

Such conditions guarantee that investment and modern technology will be placed in Canada. They also ensure that Canadians will receive their fair share of the jobs associated with Canadian production.

A second alternative to free trade is *planned* trade. The federal government can assist in negotiating agreements with other countries in which Canadian products are exchanged for foreign products.

Such arrangements can circumvent the stranglehold that certain multi-national companies currently hold with respect to specific kinds of merchandise trade. And it would ensure that we exercised some control over the ratio of exports to imports.

The real choice we face is not between free trade and protectionism but, rather, between allowing the large multi-national corporations to control our trade, or attempting to ensure that it is planned and controlled by Canadians.

— John Calvert

Canada-U.S. Intracorporate Trade 1965 and 1979[1]

Industrial Sector	1965 Imports (per cent)	1965 Exports (per cent)	1979 Imports (per cent)	1979 Exports (per cent)
Mining and primary metals	77.9	82.4	81.2	70.3
Gas and oil	80.8	62.5	87.3	53.8
Machinery and metal fabrication	79.3	95.2	80.3	76.8
Transportation equipment	67.0	59.0	81.5	83.5
Electrical products	69.7	80.0	65.0	70.3
Chemical products	55.0	34.4	68.8	80.6
Food and beverage	46.3	62.5	27.7	30.8
Pulp and paper	21.9	51.4	58.0	52.1
Other manufacturing	64.9	67.9	83.9	81.8
Wholesale trade	80.6	94.8	76.5	90.6
Other Manufacturing	35.0	100.0	68.9	46.2
Total	66.9	63.0	78.9	81.3

[1](Proportion of all import and export trade with the United States that is between foreign-owned Canadian subsidiaries and their parent companies)
Source: Economic Council of Canada *1983 Annual Review*, p. 23.

Needs Assessment for Nurses

by Barbara Surdykowski
Employment Relations Officer

In the past issues of the Newsbulletin we have introduced the concept of an Employees Assistance Program for the Nurses of Alberta.

Prior to July 31, your Local President will be seeking your input as members into the future of the EAP Program. Your participation in this data collection will assist the EAP Committee to assess the need for, interest in and support for the program and the funding it will require.

Basic Information about the Proposed EAP

Goals:

- to provide a support and treatment program to assist distressed employees and their families.
- to provide a *confidential* support network.
- to provide a support network that provides intervention prior to job performance difficulties and avoids crises.

Intervention, in the form of short term counselling, will be available in the following areas:

Physical illness
Stress related illness
Marriage Counselling
Family Crisis
Drug and Substance Abuse
Financial Planning

Referrals will be made where long term assistance is required.

Entry:

The entry into the program will be:

1. Self referral
2. Union assisted
3. Employer assisted

Confidentiality

The Employee Assistance Program allows you to discuss your personal problems and concerns in complete confidence in an understanding and professional environment away from the work place.

Cost Implications

Based on 1986 figures the estimated total cost is:

- 31.00 per member per year for the first year
- 28.00 per member per year following

In a joint program, the union would anticipate cost sharing with the Employer.

If you have been involved in work situations where a co-worker could have been assisted by this type of program, or if you yourself could benefit from this type of program, please provide your local executive with your ideas for the development of this project.

HEALTH & SAFETY

Nurses give Consent

By: Kenn Cust, R.P.N., B.A.
Psychiatric Nurses Association Newsletter May 1986.

Nurses employed in psychiatric hospitals often suffer assaults against their person, both in the form of verbal abuse and physical assaults. While the incidences of physical assaults are quite high, there are only a few cases where the nurse has pressed charges against the patient. In this paper, we are going to relate the most recent case of two nurses who pressed charges against a patient who assaulted them.

The potential implications that arise as a result of this case could have a great impact on any similar cases that arise in the future. Furthermore, it has come to our attention that a great many nurses are ignorant about what their legal rights are when they are assaulted by one of their patients. This paper will identify what their legal rights are and what procedure to follow should anyone want to lay charges of assault against a patient.

The Incident

On May 14, 1984, three patients were admitted to the Forensic Psychiatric Assessment Unit for psychiatric assessment, observation and for the purposes of determining Fitness to Stand Trial. As per hospital policy, all three new admissions were placed on Constant Observation until they could be assessed by the Duty Doctor.

During the intial admission routine one patient presented himself as hostile, aggressive and potentially dangerous. These facts along with the fact that the patient was charged with two serious offences, Kidnapping (Section 247 (i) CC) and Possession of a weapon (Section 85 CC), prompted a call to the Duty Doctor. The Duty Doctor was advised of this patient's behavior and gave an order to seclude the patient. The patient was advised of the Doctor's order and accepted this without incident. He was escorted to the seclusion room in the company of general male staff and was kept under constant observation until the arrival of the Duty Doctor.

The Duty Doctor was again advised of the patient's behavior and three male staff accompanied him to the seclusion room where he would be interviewing the patient. During the interview the patient gave no evidence of psychosis. He was oriented in all three spheres, his speech was coherent and rational and his hostile attitude was no longer manifested. He responded to the Duty Doctor's questions properly and gave no indication that he would be assaultive. When the doctor had finished interviewing him, the patient asked if he would be allowed out of the room to have a cigarette. It was explained to him that he would be allowed out of the room when staffing and time permitted.

The Duty Doctor left the seclusion room with the nursing staff following him. It was then that the patient jumped off his mattress and started striking the nursing staff. He had a cast on his left arm and struck two staff members several times. The patient was subsequently restrained by several staff and given a STAT dose of medication.

He remained in seclusion for approximately one week following the incident. Although he expressed his regrets to the ward Doctor about the assault and indicated that he would write a letter of apology he never apologized to the two staff members he had injured, personally or in writing. He remained on the ward for a total of two weeks and subsequently returned on the ward for a total of two weeks and was subsequently returned to court with a letter indicating that he was "fit to stand trial" and that he had no psychiatric disorder.

Both staff members injured in this assault were off work for several days. One was sent immediately to the Emergency Ward at the General Hospital for a possible concussion and the other remained on duty till the end of his shift and was then off for four days as a result of his injuries. Both staff members required physiotherapy for for some four months after the incident as a direct result of the injuries they had received.

The Charges

For some time there was much discussion about this incident and it wasn't until several months later that assault charges were actually filed against the patient. The main delay over laying charges was the simple fact that no one knew if charges could be laid in such cases.

The paper by Schwarz and Greenfield gives several reasons why charges are not usually laid against patients. They include the patient's legal status, the effect upon the clinical condition of the patient (if the patient is clinically ill), the question of whether or not it is justifiable to use the legal charge for therapeutic confrontation. They also raise the issue of the particular hospital's response to the laying of charges. Does the hospital discourage the laying of charges for fear of adverse publicity? The last two questions raised in their paper concerns provocation and, whether or not the nurse is prepared to defend her professional competence in a court of law.

Other issues not addressed by the Schwarz and Greenfield paper which should be taken into account are the support or lack of it, by the various other disciplines in the hospital, as well as the support of the Doctor involved, the support of the Head Nurse, co-worker support and Union support.

These are all very serious issues and anyone contemplating laying charges against a patient would be wise to give all of them due consideration. In this particular case, support was given by co-workers, the Head Nurse, the Ward Doctor and the Union. The other disciplines within the hospital paid little attention to the whole affair. As far as the Hospital Administration was concerned both staff members were interviewed about their laying charges and support was neither offered nor withheld.

Notwithstanding all of these considerations, a call was made to the City Police who informed the staff members that charges could be laid. He also informed the staff members that it would be unlikely that anything would result from laying the charges given the fact that the incident occurred in a Psychiatric Hospital.

The procedure for laying charges proved to be quite simple. The City Police were advised that two staff members wanted to lay charges against a patient who had assaulted them some months earlier. A constable came to the hospital and took statements from the two staff. A few days later both staff members were advised to see the Clerk of the Provincial Court in order to proceed further with the charges they had laid. An official statement, "The Laying of Information", was given to a Justice of the Peace and two counts of assault causing bodily harm were filed against the patient.

In August 1980, a Preliminary Hearing took place to see if there was sufficient evidence to proceed to trial. After hearing all the evidence presented by the nurses, the arguments presented by the Prosecuting Attorney and the arguments put forth by the Defence Attorney, the Presiding Magistrate ruled that a trial should take place. The Defendant chose Trial by Jury as opposed to a Trial by Judge alone.

The trial took place in October 1985. The defendant was found not guilty. As it was a Trial by Jury, no reason was given for the verdict. However, there are only two defences for an assault charge, consent and intention, and the Defence Attorney argued both of them.

During the trial the honesty of the nurses was not disputed. That an assault took place and that the two nurses were injured during this assault seemed to be taken for granted. The main argument presented by the Defence Attorney was that both nurses consented to be assaulted (and by logical implication, all nurses working in Psychiatric Units consent to be assaulted). He argued that they chose to work in a Psychiatric Hospital knowing full well that being assaulted by patients was a fairly common occurrence, an occupational hazard so to speak. Thus, he concluded, given the fact that the nurses consented to being assaulted, his client could not be found guilty.

His second argument involved the defence of intention. The defence of intention places the burden of proof on the Crown to prove that the defendant intended to assault the two staff members, rather, his client was merely trying to get out of the room so he could have a cigarette.

It will never be known why the jury returned a verdict of "Not Guilty" for they do not have to give reasons for their decision. Nevertheless, the verdict does raise at least two important issues for nurses working in psychiatric settings.

The Conclusion

The most important issue to arise as a result of this case is the argument that nurses working in a psychiatric setting give their consent to be assaulted. Once patients discover that they can assault nurses without suffering any possible legal consequences, then we can expect the number, the frequency and the severity of assaults to increase.

The second issue to arise as a result of this case is the implication that nurses employed in psychiatric settings have no legal right to work in a safe environment. Assaults by patients are to be viewed as an occupational hazard, a fact of life nurses have to learn to live with.

Needless to say, both of these positions are unacceptable. As nurses, we have to assert ourselves. These issues must be addressed by our Professional Associations, by our Hospital Administrators, by our co-workers and by our Unions. Failure to do so can only result in the demise of what, up until now, has been a fairly rewarding career in a noble profession.

Addendum

This paper was originally written on January 20, 1986. On *February 1, 1986, two nurses were* brutally attacked by a patient wielding a pool cue. Both staff members suffered severe physical injuries and were hospitalized following the assault. The attack was perpetrated by LGW patient residing on a minimum security ward. Surely one would not want to argue that these two nurses consented to this attack. Yet that is just the implication to be derived given the decision reached in the aforementioned case. Furthermore, this latest attack on these two nurses substantiates that part of our conclusion relating to the severity of attacks.

OTHER NURSES

NFNU Launches Technological Impact Study

Decisions are being made about the use of computers for the management of patient information in Canadian health care agencies with minimal research by the largest professional group in the health care delivery system closest to the prevailing health needs of Canadians - the Registered Nurses. Therefore, the National Federation of Nurses' Unions (NFNU) developed a research proposal to examine the impact of technology on health care and nursing. The proposal has since been approved by the Minister of Labour who announced on March 24, 1986 a $95,412 grant under his department's five million dollar Technological Impact Research Fund. The study, INFOSTAT I, will be the first of its kind since the advent of nursing informatics.

A preliminary survey by the Federation of hospitals across Canada indicates that nurses in nearly every acute care facility will be using patient information management systems with the next five years. Therefore, information is needed "STAT" to determine the effects and implications of using computerized patient information management systems on nurses, nursing and patient care. INFOSTAT I, a national nursing study by nurses for nurses, will respond to this need by describing these effects and implications from the Registered Nurse's perspective and will provide nursing leaders with information to direct and support decision making for the current and future development of computerized patient information management systems.

Currently, in Canada, professional nursing is extremely vulnerable to certain groups who want to determine the nature and content of computerized patient information management systems. Nurses have not been actively involved in planning and implementation even though they are accountable for information contained in these systems. Therefore, a nationally co-ordinated network is needed to provide quality information for effective decision making, by nurses and related health professionals, to ensure that appropriate and rational decisions are being made about the use of computers in health care. "INFOSTAT I will enable nursing union leaders to be pro-active in integrating computerization in our work settings," said NFNU President Kathleen Conners, "and nurses must, while there is still time, develop a knowledge base to guide negotiations with hospital administrators to ensure that the quality of patient care and the work environment for nurses are improved as a result of computerization."

During a Federation seminar on computers in February, keynote speaker Dr. Kathryn Hannah, a Canadian leader in nursing informatics, respected worldwide, aptly summarized the stature of this initiative. "INFOSTAT I will give us essential information that will allow us to forge new frontiers in the patient-nurse relationship," she said. Her American counterpart, Dr. Marion Ball, also an international lecturer and consultant, said that "although there have been many studies on how computerization affects hospital management, never has there been a project specifically designed to investigate the impact of computers on the working practise of nursing care. This is why my American colleagues and I are so excited about INFOSTAT I."

The eighteen month, three part study, will employ both qualitative and quantitative research methods under the direction of a research committee composed of a principal investigator, a co-investigator, a NFNU representative, and four regional representatives from provincial nursing unions.

The focus of the initial phase of the study will be to develop hypotheses about the impact of computerized patient information management systems on nurses and on patient care through intensive direct contact with state-of-the-art health care facilities and suppliers of health care equipment. Fifty in-depth audio-taped interview will be conducted with a representative sampling of Registered Nurses employed in hospitals and extended health care agencies across Canada who are required to use computerized patient information management systems. Interviews are planned for Vancouver,

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Consent Form

By: Irene Gouin, member U.N.A. Local #79. With special thanks to Deborah Weber for her support and assistance.

Sometime ago I requested that United Nurses of Alberta Presidents send me a copy of the specific consent form in use in their health care facility.

To date I have received nineteen such forms. I have analyzed these consent forms with guidelines for legal requirements of an acceptable specific consent form and its protection of the patients/client.

A statistical breakdown of the nineteen forms are as follows: eighteen of the forms came from hospitals and one came from a Community Health Unit, three forms came from the North District, seven from North Central District, seven from South Central District and two from the South District.

Although the following report deals mainly with consent forms, because some locals sent general consent forms, I will briefly discuss the general consent forms first.

GENERAL CONSENT

General consent forms have less weight than the patient's ongoing express (behavioral or verbal) consent to various treatments and laying on of hands by others. This form is hard to recognize as valid from the patient's point of view. The form is blanket in nature, that is the patient, at the time of signing, is unaware of all the treatments, personally delivering these treatments and any risks or discomforts associated with the same. The patient therefore, is making an uninformed decision, resulting in an invalid consent. Further such a consent is not a valid waiver to information as the patient is unaware that this would be the purpose of the consent. Ellen Picard, in her book *Legal Liability of Doctors and Hospitals in Canada*, expressed the principle well:

> "Many forms presently in use are 'blanket consent' authorizing unspecified additional or alternative procedures. Such broadly worded consent might be so indefinite that a court would give it little weight."[1]

I have found the majority of General Consent forms troublesome for an additional reason. The general consent form was structured in such a manner that the patient's signature also authorized the release of confidential information to insurers. Authorization for disclosure of confidential information should be a special consent whereby the patient can become aware of what specific information is to be released and to whom. The risk of general release of information to any insurer may present a situation where the insurer's knowledge of the patient's condition may exceed the patient's.

In 1980 Ontario's Krever Royal Commission on Confidentiality of Health Records made the recommendation: "That institutions have patient consent forms for disclosure of information and that any disclosure without the patient's written consent, the patient should have that statutory right to sue for a minimum of ten thousand dollars."[2]

One Institution's general consent form authorized the publication of birth information. Again the above rule applies; the exact information to be given to the media should be spelled out is a separate form.

SPECIFIC CONSENTS

Before presenting my analysis, I will review what constitutes a legally valid consent.

A legally valid consent has the following five criteria to be met:

1) Patient gives his consent voluntarily without coercion.
2) The patient must have the capacity to consent.
3) The patient must be mentally competent to give consent.
4) The consent must be specific to procedure and person performing the procedure.
5) The patient must be informed to the procedure, relevant risks, expected outcome prior to giving consent.[3]

The complete consent form should have evidence of all the above criteria in its format. It would be difficult to include the first criteria but the other four is an easy matter.

Also keep in mind the patient is not signing a contract. She/he is just agreeing to the procedure to be done by specific personnel and accepting the risks involved.[4] Therefore the patient should be informed of:

1) Material risks, i.e. those risks of serious consequences, for example paralysis or death, no matter how remote they are of occurring.
2) Special or unusual risks. These risks are specific to a particular procedure, and may not be of serious consequence. For example the post myelogram headache, or of more serious consequence, the perforation of the bowel with a sigmoidscopy.[5]

Finally, any specific questions by the patient must be answered to constitute a valid consent.[6]

However, there are three situations where the Health Care Professional may withhold pertinent information:

1) When the patient waives access to such information.
2) Common risks such as post-op pain, gas gangrene, scarring, infection. But these may become special or unusual risks if the probability or severity of occurrence increases due to other health care problems the patient has.
3) Where emotional factors are involved that disclosure of risk would cause mental and physical harm to the patient. However Professor Somerville states in "*Structuring the Issues in Informed Consent*, this does not apply when the only reason is that disclosure may cause the patient to refuse treatment."[7]

A specific consent is unnecessary only in an emergency situation where a patient is not capable to give consent. A physician can administer treatment, providing that there is written opinion by two physicians that the treatment is necessary and to the knowledge of the physicians the patient has not a history of refusing such treatment.[8]

DATA ANALYSIS

Hospital Consents

In reviewing the forms, I was surprised that a number of the hospitals required spousal authorization for sterilization procedures. There is no legal requirement for spousal consent.[9]

To go on, a number of the consents do not have an area for the physican to sign that he/she did explain the procedure, relevant risks, and expected effects to the patient.

Without the physician's signature it is not clear that the patient received the information. Later it could be disputed that the information came from an intern, nurse or cleaning lady. Without being aware of the physician's particular technique and any associated risks to the technique, these other parties may fail in giving the necessary information for the patient to make an informed decision, therefore making the consent invalid. Also the consent form for Intravenous Pyelogram that was sent to me does not even have who will specifically be performing the procedure.

To continue, many of the specific consent forms had the following or similar statements:

> "I acknowledge that no guarantees have been made to me as to the results of the operative procedure."

I am concerned that this statement may be giving an inaccurate reflection of the law. As one layperson told me, this statement gave her the impression that the hospital was attempting to decrease her chance of compensation in the event of negligence.

I feel there is really no legal requirement to put such a statement in a consent form as no one can be held responsible for unexpected, unforeseeable complications. However, as stated previously, anticipated effects of the procedure must be disclosed to the patient prior to obtaining the specific consent. It is for this reason I find another hospital's specific consent form more reflective of protecting the patient:

> "The anticipated effects and nature of the procedure which has been explained...."

All the submitted consent forms made reference to the "additional or alternate treatment or procedures that may be done to the patient based on the physician's opinion." A couple of common examples are:

1) I also consent to such additional or alternative procedure(s) as, in the opinion of the above named physician, are immediately necessary."
2) I recognize that, during the course of the operative procedure(s) unforeseen or unknown conditions may necessitate an additional or different procedure(s)...further authorize any request the above named physican...in his professional judgement deems necesary and desireable."

The word "desireable" is of a broader nature than just the word "necessary". Desireable to whom, the patient and physician may not agree on what is desireable, especially since the patient-physican contact may be extremely limited.

Although the second example is more descriptive, additional or alternative procedure(s) would be limited to emergency situations or where a repetition of anaesthesia would be harmful to the patient. Essentially any new procedure requires a specific consent. Janet Storch, in her book, *Patients' Rights: Ethical and Legal Issues in Health Care and Nursing*, states:

> "Each procedure requires consent specific to procedure performed and the particular Health professional or class of professionals actually performing the procedure."[10]

In a consent where additional procedures are agreed to on the basis of desireability, the patient may, in fact, unknowingly be waiving the right to consent to every new procedure. However the patient may voluntarily waive this right at any time.

In addition, all the consent forms analyzed made reference to the fact that according to the physician's discretion, others may be chosen to perform the procedure(s). Ellen Picard states the risk that the consent is inadequate is on the physician's shoulders as he/she is to use sound professional discretion.[11]

Mary Philpott further reinforces this statement:

> "In view of the fact that the patient has consented in essence to take risks in the performance technique of a particular surgeon the patient may very well be able to make a case that he did not accept the risks of another physician doing the procedure. Therefore the consent would reflect this reality that other medical personnel will be involved in the procedure..., but the involvement of the other personnel should be "as required or necessary."[12]

It was encouraging to note that a number of the consent forms required rationale as to why the consent had to be obtained from someone else other than the patient (i.e., legal guardian). One particular consent form had an area to tick off as to how the consent was obtained; either by telegram, phone or letter. A few of the consent forms allowed for two witnesses' signatures in the case of a telephone consent.

Community Health Unit

Now I have a few remarks in regard to the Community Health Unit's consent forms.

I found the information on the consent forms excellent. However the consent form did not require the nurse to acknowledge in writing that she gave the explanation. For example: an individual other than the parent accompanies the child for his/her immunization. The parent sends a message of doubt or questions with the attending adult. In this instance the nurse should be able to document that she contacted the parent by phone to answer any questions.

Unique Statments

Before closing I wish to share some of the unique statements found in the forms analyzed. These statements were either extreme, and seemed to lack discretion, or, were progressive in protecting the patient/client.

One consent form provided an area at the bottom for either party to write additional information. This allows for further communication that the patient or physician feels is important. For example, the patient may want to alter the conditions of the consent, express a choice of anaesthesia or even point out that he/she has capped teeth.

Another form called for an explanation of the circumstances where an informed consent could not be obtained in an emergency situation. This method of double checking helps ensure that valid reasons for not obtaining a specific consent form are documented.

A third consent form states:

> "...examination, investigation, treatment or operation...."

By inserting the work "or" the consent is limited to one anticipated procedure. This intent ensures that an informed consent will be given for each procedure. In other words, ideally, a diagnosis has been established by an investigative procedure, the patient will have an opportunity to consent to the recommended treatment after hearing all alternative treatments. (See Appendix IX.)

On another consent form, reference is made for authorization of observers for the purpose of advancing medical education. A patient could get the impression that this is a condition to the consent, therefore if surgery is desired, the patient must agree to having observers present during the surgery. However, no patient is under any obligation to do anything to advance medical education. It should be made clear on the consent that surgery will be performed even if the patient refuses to have observers present.

Another facility's consent form began with a paragraph explaining that death can occur due to known and unknown causees. Although I strongly support that patients are entitled to all relevant information necessary to make an informed decision, I feel that this paragraph is anxiety provoking and unnecessary. Thus it is apparent that discretion is necessary when developing a consent form.

Finally, I was surprised to find that one facility was using blanket consent forms to obtain specific consents. This form made no reference to specific procedure, done by whom and who gave the relevant information to the patient.

I was also informed in writing that another facility's general consent was being used to include authorization for all surgery done in the operating room. These consents are invalid as they request blanket authorization from the patient for any procedure.

Conclusion

In closing, I wish to reinforce the fact that the patient's signature on a consent only means that he/she is willing to take the known risks involved in a specific procedure done by a specific performer's techniques. The specific consent form should have evidence of the same on it. Also remember patients always have the right to change his/her mind even after the consent is signed.

Editor's Note:

The complete report along with a listing of all references used by Gouin is available in the U.N.A. provincial office.

General Consent forms not Valid Waiver to Information

ASK THE PARLIAMENTARIAN

By: Flodia F. Belter
Registered Procedural
Parliamentarian

IRREGULAR BALLOT: Irregularities on ballots such as misspellings, errors in grammar or punctuation, or putting a check mark in place of an X should be ignored as long as the meaning is clear.

In the case of elections, the candidate for whom it was intended should be credited with the vote even though her name is misspelled or the directions on the ballot are not followed exactly.

If there is real doubt concerning the intent of the ballot, the tellers may invalidate it or they may submit it to the assembly for instructions. In any case, the tellers should report all irregularities.

JOURNAL: Although the record of the proceedings of an organization is usually called the minutes, the term journal is sometimes used. Minutes and journal are identical in Parliamentary Law usage.

LEAVE TO WITHDRAW OR MODIFY A MOTION: Before a motion has been stated by the chair, the maker of the motion may withdraw or modify it without permission. After it has been stated, it is the property of the assembly and the maker must be granted leave or permission to withdraw or modify it.

If a motion has been made and seconded and the maker modifies it before it has been stated by the chair, the seconder may withdraw his second, if he does not favor the motion as modified. After the motion has been stated, if permission is granted the maker to modify his motion, the second may be withdrawn.

MAJORITY DEFINED: In voting, a majority is defined as one vote more than fifty percent of the vote cast. Blank ballots are not counted as a vote cast, but illegally marked ballots are counted and reported as such. (Suggestion: do not make a provision that reads as follows, "the required majority vote is fifty percent plus one of the votes cast") this provision makes the vote requirement higher.

MAJORITY VOTE, MOTIONS REQUIRING ONLY: When it is not indicated otherwise, motions usually require only a majority vote. All motions not listed as requiring a two-thirds vote may be passed by a majority vote.

QUESTIONS FROM THE MEMBERSHIP:

Q. If previously passed motions which still remain unexecuted have become obsolete, what steps should be taken?

A. Move to rescind them.

Q. What is the distinction between "Appoint" and "Elect"?

A. "Appoint" is selection by the Chair". "Elect" is selection by a vote of the assembly.

Q. When is a postponed question entertainable?

A. Under unfinished business, usually at the next meeting.

Q. What do Parliamentarians mean by "RESTORATORY MOTIONS" and illustrate some?

A. A restoratory motion is one which is once again open to discussion and restored to the assembly for further consideration. Hence, motions which have already been considered can be again reviewed. The following are illustrations of restoratory motions:

(a) To reconsider
(b) To rescind
(c) To ratify
(d) To take from the table.

Q. If a vote is taken when a quorum is not present and a point of order is made suggesting the absence of a quorum and the vote is objected to on that ground, what should be done?

A. A roll call vote is immediately in order.

You are invited to mail or telephone your questions to:—
Flodia F. Belter
Registered Procedural
Parliamentarian
9728-82 Avenue
Edmonton, Alberta
T6E 1Y5
Telephone: 439-5703 or 439-1327.

LETTERS

June 4, 1986

To The Editor,

This letter is in response to the Health and Safety article, Smoking on the Job, in the February, March 1986 issue of Newsbulletin.

Health and Safety Committees in all hospitals in the province will find themselves very busy in the next few years trying to find an easy solution to the complex problem of smoke in the workplace. How do you balance the preference of smokers to smoke with the non-smokers' desire to breathe clean, safe air? That's a tough question to which there is not an easy solution. And whatever is determined to be the answer will not likely satisfy everyone. There will always be people who disagree with the obvious solution.

Perhaps workers, committee members and unions could look objectively at cigarette smoking and some associated facts.

Cigarette smoking is not listed as a 'right' within the charter of human rights. The Alberta Human Rights Commission has ruled that employers are within their rights to legally discriminate against smokers if they so choose. Consequently smoke-free hospitals are perfectly legal and acceptable.

Nicotine is one of the most addictive substances known to man. Cigarette smokers are addicts. I don't know another addiction that is condoned by unions, or by health-care professionals. The treatment of choice for addictions involves removal of the addictive substance, and support during withdrawal with counselling and encouragement following cigarette smokers who find themselves unable to quit, are addicted to nicotine and in order to combat the addiction, they need help.

Unions are said to be "caught in the middle" because they represent both smokers and non-smokers. So also do unions represent heroin addicts and non-heroin users, and also people with severe body odor and no body odor. They represent excellent employees and not so excellent employees. The bottom line is that unless cigarette smoking is eliminated or, at best, confined to separately ventilated areas where non-smokers are not required to be, the preference of non-smokers is not being addressed. If one extrapolated national figures to Alberta, all unions in the province probably have a majority of members who are non-smokers.

The most common cause of fires is cigarettes. From a safety point of view, eliminating or severely restricting areas where smoking is allowed is definitely providing a safer work environment. How many times have you seen a smoker leave a lit cigarette burning in an ashtray—an ashtray often already overflowing with butts?

Cigarette smoke has more than fifty known carcinogens and sidestream smoke has greater amounts of some of the more potent carcinogens. Tobacco smoke is a dangerous substance. How can any health and safety committee ignore these facts?

Smoking is said to be a method of handling stress. Perhaps we should have a look at all the other "side effects" it has while helping the individual cope. Cigarette smoking is the single most important cause of lung cancer. It is one of the three major risk factors associated with heart disease. Lung cancer will, in this decade, overtake breast cancer as the leading cause of death in women. Cardiovascular disease is the number one killer of North Americans. No wonder the Alberta Heart Foundation and Alberta Lung Association have so many free pamphlets encouraging people to stop smoking! Cigarette smoking contributes to osteoporosis. Cigarette smoke is a potent allergen, contributing to asthma in children and emphysema in adults. Sidestream cigarette smoke is known to affect unborn babies. Pregnant mothers who smoke statistically have a higher frequency of miscarriage, and lower birth-weight babies. Health and Safety Committees and union officials simply cannot ignore this information. In the best health interests of everyone, cigarette smoking must be curtailed.

Here are a few more facts. Cigarette smoking adversely affects work performance. Smokers frequently take unscheduled breaks to "light-up". It has been estimated that the smoking ritual contributes to 18.2 days annually of time lost per smoker while that worker is on the job. Smokers, on the average, have greater amounts of sick time than non-smokers. 1983 estimates from Health and Welfare statistics estimated that smoking cost Canadian businesses $1.2 billion annually in lost productivity. Smokers also, on the average, have lower energy levels and contract more colds and flu bugs than non-smokers.

Another very significant but seldomly raised fact is that modern ventilation systems in fact, do not cleanse the air of particulate matter, carcinogenic particles and noxious gases in cigarette smoke, but instead, just spread it around. The size of the particles that we are able to breathe into our lungs is very tiny. To filter these particles out is only possible with a highly complex, expensive industrial filtering system. And the gases, of course, cannot be filtered, only diluted with fresh air.

As you can see, the issue is a complex one. First, the government has recognized that smoking is not a "right", but a preference. Second, to approach this issue with understanding involves recognition that smoking is an addiction and should be treated as such. Smoking is becoming more and more unacceptable. It is the most significant source of indoor air pollution today. The employer should take reasonable steps to protect the non-smokers. If reasonable steps do not solve the problem, a policy must be set, a policy of no smoking. A reasonable approach would ban smoking in the workplace while at the same time introducing stress management seminars and perhaps the opportunity for aerobic exercise on lunch breaks. If management and union cannot agree to a ban, the only alternative solution is a room vented separately to the outside, where smokers can indulge in their addiction during scheduled breaks.

Respectfully,
Debra Martin, R.N.
Staff Nurse - Ponoka General Hospital

For more specific information, resource material and help in formulating policies may be obtained from:

1. Alberta Interagency Council
   - Calgary Chapter
   #200, 1609-14 Street S.W.
   Calgary, Alberta
   T3C 1E4
   Ph. 228-4487
2. Alberta Lung Association
   10618 - 124 Street
   Edmonton, Alberta
   T5N 3X4
3. Alberta Heart Foundation
   1825 Park Road SE
   Calgary, Alberta
   T2G 3Y6
   Ph. 264-5549
4. Group Against Smoking Pollution
   P.O. Box 12067
   Main Post Office
   Edmonton, Alberta
   T5J 3L2
   Ph. 424-GASP
5. Canadian Cancer Society
   Ph. 244-2791
6. Canadian Addictions Foundation
   Pacific Plaza
   Box 702
   10909-Jasper Avenue
   Edmonton, Alberta
   T5J 3M9
   Ph. 421-0435

LABOUR NOTES

Unions of Canada A bright future predicted

A study recently released in the Vector Union Report, a bi-weekly newsletter on labour management developments, predicts that unions have a bright future in Canada.

The study cites an opinion poll that says 55 percent of respondents preferred to work for a unionized company, with 35 percent opposed.

It predicts that in 15 years unions will represent 45 percent of all non-agricultural workers, compared with about 33 percent now.

The opinion survey which questioned 600 Ontario adults, found that job security and pensions were cited by 95 percent as reasons for wanting to join a union. Other commonly cited reasons included fighting discrimination, enjoying work more and "the right to talk back to supervisors."

The study forecasts that major growth in union strength in the next decade will occur in the service sector, such as banks and retail trade. Less than 10 percent of those workers are currently unionized.

The report indicates that neither progressive management or modern management has eliminated the need for unions. From the data the report concludes that "the public sees nothing around that can replace what unions do on behalf of workers."

REMINDER

For hospital employees employed subsequent to January 1, 1986 and who terminated prior to June 3, 1986, please note: that you must apply in writing to your former employer by no later than August 2, 1986 for any retroactive monies owing.

UNAVERSITY

DATE	DISTRICT	WORKSHOP	LOCATION	ERO/EPO
August 25	N.C.D.	Assertiveness	Edmonton	WD
August 27	S.C.D.	Assertiveness	Calgary	BS
Sept. 9	S.D.	Local Admin I	Lethbridge	
Sept. 16	N.C.D.	Local Admin I	Edmonton	
Sept. 17	N.D.	Local Admin I	Grande Prairie	DT
Sept. 18	S.C.D.	Local Admin I	Calgary	MM
Sept. 24	C.D.	Local Admin I	Red Deer	NF
Oct. 1	S.C.D.	Ward Rep	Calgary	NF
Oct. 2	S.C.D.	Grievance I	Calgary	NF
Oct. 7	N.D.	Grievance I	Grande Prairie	BS
Oct. 9	C.D.	Grievance I	Red Deer	WD
Oct. 15	N.C.D.	Ward Rep.	Edmonton	
Oct. 16	N.C.D.	Grievance I	Edmonton	
Oct. 22	S.D.	Ward Rep.	Lethbridge	MM
Nov. 5	N.C.D.	P.R.C. I	Edmonton	
Nov. 6	C.D.	P.R.C. I	Red Deer	BS
Nov. 13	S.C.D.	P.R.C. I	Calgary	WD
Nov. 18	S.D.	P.R.C. I	Lethbridge	MM
Nov. 25	N.D.	P.R.C. I	Grande Prairie	BS
Dec. 2	N.C.D.	Health & Safety I	Edmonton	DT
Dec. 2	S.C.D.	Health & Safety I	Calgary	TR
Dec. 3	C.D.	Health & Safety I	Red Deer	NF
Dec. 4	N.D.	Health & Safety I	Grande Prairie	DT
Dec. 4	S.D.	Health & Safety I	Pincher Creek	MM

On the Bricks

On the labour relations front, the biggest story in Alberta, is the dispute in the meat packing industry, between Gainer's and United Food and Commercial Workers Local 280P.

In the red meat industry negotiations between workers and a major employer such as Canada Packers or Burns results in a collective agreement which sets the stage for settlements throughout the entire meat packing workforce.

Such a settlement pattern was broken 2 years ago when Peter Pocklington, owner of Gainers introduced a two tiered salary grid. The attempt is again to break the settlement pattern.

Members of United Food and Commercial Workers Local 280P began strike action on Sunday June 1, 1986 at 12:01 A.M. The primary objective is to obtain parity with workers employed by other meat packing plants. For members of the union this means a change in wages from a start rate of $7.00/hour and a base rate of $11.99/hours to $9.38/hour and $12.50/hour. An additional statutory holiday, double time for overtime and the deletion of mandatory overtime are also at issue. Health and Welfare benefits too are of concern. Currently, employees with 0 - 4 years of seniority have no employer paid benefits. Those with 5 - 9 years of seniority get 50% of the cost of benefits paid by the employer, while others with 10+ years of service get 100% of the cost of benefits paid by the employer. The Union is seeking 100% employer payment of all benefits for all employees.

The strike by UFCW Local #280P is one filled with intense emotion. Such was set off by Gainers when it advertisied for people who were prepared to cross picket lines. The strike breakers are being paid $8.00/hour, a dollar an hour more, than Gainers has previously paid its regular newly hired workforce.

Members of UFCW and their supporters have been diligent in their attempt to shut down operations. Trucks of supplies and hogs, buses loaded with strikebreakers, have been stopped daily from entering plant grounds. On day 2 of the strike a court injunction obtained by Gainers limited picketters to 6 per plant gate and 42 in total. On day 3, 115 people were arrested for violating the injunction, including Dave Werlin, president of the Alberta Federation of Labour, Pete Boytzun, business agent, UFCW: Vair Clendenning, spokesperson for the Building Trades Council and Bill Marlow, president of the Carpenters Union. By day 4 of the strike arrests totalled 134 people and Pocklington publicly vowed to "never sign" another Collective Agreement. On day 5, 98 people were arrested including John Ventura, president of UFCW Local 280P.

The Alberta Federation of Labour held a meeting on day 6 of provincial labour representatives to co-ordinate support for the strikers. The following day a rally of 4,000 people was held at Gainers.

On day 10 of the strike, a second injunction order was issued. It states that no one who is not a member of UFCW Local 280P can picket Gainers. It also establishes a 100 foot "off-limits zone" around the plant, wherein, if more than 3 people gather they are breaking the injunction.

Support for the strikers has been mounting steadily throughout the dispute. Thursday, June 12th saw between 8 - 10,000 trade unionists and civil libertarians march to the Legislature and Edmonton City Hall. They called for the government to amend Alberta's labour legislation to prevent employers from hiring scabs during the course of a labour dispute.

As well, developments on another front should put pressure on Gainers to settle. A memorandum of settlement between Fletchers of Red Deer and the United Food and Commercial Workers Local there, has recently been reached. A strike by workers at that plant began the day after Gainers. During it, 100 people were arrested. The settlement is based on the industry standard.

The Minister of Labour, Ian Reid has appointed a Disputes Inquiry Board. To date, members of United Nurses of Alberta has been the only unionized workers subject to this process. Al Dubensky is the sole member of the Board, charged to enquire into the dispute and if possible effect a settlement. His inquiry has begun but there is little result, if any to date. If U.N.A.'s experience holds true, there is likely to be little in the way of satisfaction from this kangaroo court.

Today, support pickets are on the lines with members of UFCW Local 280P. The injunction order remains. Police, both RCMP and Edmonton City are out to enforce it. It is estimated that 1/3 of Edmonton's city policy force have been assigned to oversee this dispute. Holidays have been cancelled, the overtime budget has been blown. Tax dollars are being spent to secure Mr. Pocklington's version of labour justice.

And as if he needs more, Gainers has taken over the pension plan of its workers. Ten million dollars in pension benefits looks to be lost by members of UFCW.

The end has yet to be told....

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Questionnaire Responses Summarized

Questionnaires regarding negotiations and the health unit strike went out to all members of U.N.A. health unit Locals in April. The deadline for their return for compilation for the May Board meeting was May 15th. At that time 43 of a possible 300 questionnaires had been returned. These were summarized and presented to the Board at its meeting during the week of May 26th. The Board at that time decided that in order to review the material properly, more time was required. Decisions as a result, in respect of future negotiations, and, matters related thereto will not be made until the August Board meeting during the week of the 11th. As of this time 16 additional questionnaires have been received for summarizing and review.

Continued from page 5

Calgary, Edmonton, London, Toronto, Montreal, Saint John, Moncton and Springdale, Newfoundland in which, each subject, will be asked to describe, from their perspective, the effects of computerization on nurses and patient care.

The hypotheses generated in phase one (expected duration five months) will form the basis for the next phase. In this a questionnaire will be prepared to measure response to the hypotheses, collect baseline data for policy development by Canadian nursing leaders, and illuminate educational and work related characteristics of the respondents. All Registered Nurses in Canada who are required to use computerized patient information management systems (approximately 5000) will be requested, by mail, to complete the questionnaire. Collection and statistical analysis of data is expected to take six months.

Reporting is the final phase. Analysis and interpretation of finds will describe the impact of computerized patient information management systems on nurses and on patient care, relate this impact to the work environment and educational preparation of the respondents, and emphasize the implications of these findings for nursing leaders in general and nurses' unions in particular. Copies of the report will be prepared in Canada's official languages and the principal investigator and co-investigator will be available to present their research report in either French or English to nurses' unions and other interested groups throughout Canada.

New codes are evolving for nurses and "nurse informaticians" are fast becoming a reality in the health care work environment. In this era of automation, nurses will be challenged as never before to define their distinctive contribution to health care and to develop ways of using technological advances to their full potential for the benefit of both patient and nurse. INFOSTAT I will help uncover the most appropriate alternatives for incorporating the use of computers in caring for patients more effectively and humanistically, will illuminate ethical and legal implications of technology, and will provide nurses across Canada with a data base to access this much needed information.

If you work you are working in an acute or chronic care facility where you are required to use computerized patient information management systems please contact:

INFOSTAT I Office
2 Susan Place
Dartmouth, Nova Scotia
B3A 4M3
(902) 469-5464

Your input is required to direct nursing futures.